



PEAK HEALTH

Case Study

Client: **TRUIST** 

Peak Health is a high-touch, outcomes-based, lifestyle behavior change program that is Registered Nurse-led and data driven. Nurses deliver onsite, individualized health evaluation, coaching, and navigation with personalized goals to improve health and compliance with clinical care guidelines.

BB&T, now Truist, began using Peak Health in 1989. This case study highlights the significant impact of the nurse-based employee wellness program at Truist.

Peak Health: Program Overview

The program is based on data and clinical grade science. It requires participants to complete a comprehensive set of labs and biometrics every year. Participants also must complete a Health Assessment which includes questions about their physical activity, diet, alcohol consumption, smoking, basic biometrics, and stress.

During a participant visit, a Peak Health nurse will review these data points and conduct tests to evaluate the participant's cardiovascular fitness and body composition. The nurse considers all of these factors to "phase" the participant according to their health risk, with Phase 1 being the unhealthiest and Phase 5 being most healthy. The nurse also coaches participants on ways to improve their phase score, encourages them for actively pursuing their health goals and previous advice, and suggests ways to address issues like stress, specific diseases and conditions.

The nurses meet with a participant, more or less frequently based on their health status, behaviors, and risk factors, sometimes as often as every 4 months. In Truist's program, called "LifeForce," participants also receive discounts on their health insurance premium contribution according to their phase and other factors (e.g. salary band, # of family members on health plan).

"The Peak Health program helps drive real behavior change by empowering people with information about their health.

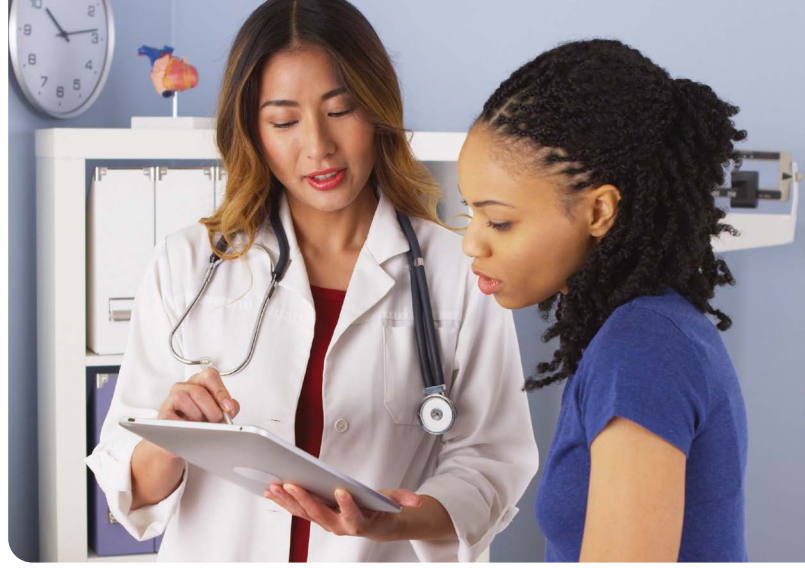
It also establishes a bond between the employee and the nurse, such that the employees not only understand what they should do to improve their health and well-being, but also commit to accomplishing their goals by their next meeting.

We see significant engagement of high risk employees who would benefit from interventions, and this has led to more than a 10% reduction in annual medical claims."

– Steve Reeder, EVP,
Director of Benefits

Program Results

In the LifeForce program, a significant portion of the employee population is motivated to modify their behaviors for better health. This is because Peak Health nurses, as trusted clinical professionals, not only provide education and encouragement on healthier behavior, but also control health risk assessments that drive premium contribution discounts. This combination helps participants feel more accountable for their behaviors and motivates them to improve. These improved health behaviors have translated to the results described in the next three sections.



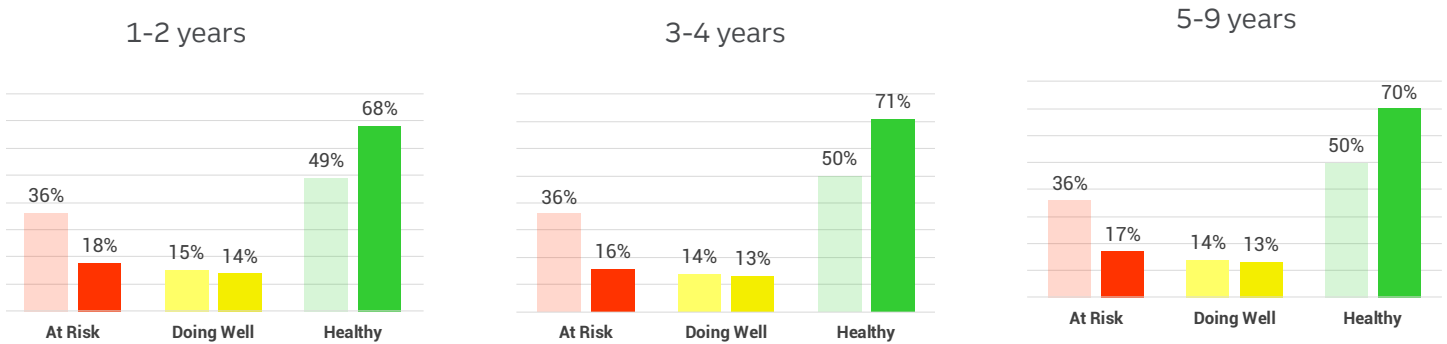
Sustained Improvements in Health Risk and Status

A frequently asked question regarding wellness programs is whether or not results are sustainable.

Figure 1 shows that the Peak Health program at Truist has delivered consistent results for program participants, regardless of how long they were in the program. In general, the number of participants considered to be “At Risk” was cut in half (from 36% down to 17-18%) over the measured period. Additionally, there has been a marked increase in the number of people in each cohort who have become healthy over that period. According to this data, the program sustainably improves health for a portion of the population.

Figure 1: Health Status Progress for Cohorts Separated by # of Years in Program

Notes: At Risk = Phase 1 or 2, Doing Well = Phase 3, Healthy=Phase 4 or 5



Improved Modifiable Risk Factors and Financial Impact

Reduction in modifiable risk factors helps avoid the downstream risk of chronic disease. Table 1 shows a subset of the modifiable risk factors that the program has demonstrated significant ability to eliminate through the course of participants' engagement in the program, along with the decrease in excess annual costs associated with these risks. For example, with obesity, 5,158 people were measured as obese when they entered the program, but by their last visit, 1,785 of those participants (35%) are no longer obese. This translates to \$1,785,000 in annual savings achieved from eliminating the excess medical costs associated with obesity. Across just the 5 risk factors in the table, the estimated annual savings in eliminated excess medical costs is over **\$6.2 million**.

Table 1: Improving Modifiable Risk Factors*Excess Medical Cost Savings Resulting from Elimination of Modifiable Risk Factors over Lifetime in the Program*

Risk Factor	Initial # Starting Program With Risk Factor	Still At Risk	Risk Eliminated While In Program	% Risk Eliminated	Excess Annual Medical Cost Per Risk ²	Total Excess Medical Costs Avoided
High Blood Glucose ¹	3,242	2,386	856	28%	\$1,694	\$1,450,064
Obesity ¹	5,158	3,373	1,785	35%	\$1,000	\$1,785,000
High Blood Pressure ¹	546	184	362	66%	\$1,077	\$389,874
Using Tobacco ¹	1,082	494	588	54%	\$659	\$387,492
Inactive ¹	5,938	703	5,235	88%	\$421	\$2,203,935
TOTAL						\$6,216,365

¹ Mayo Clinic Health Assessment guidelines

* Obesity: BMI ≥ 30

* High Blood Pressure: > 140/90 mm Hg

* Tobacco use

* Inactive: < 30 min of moderate activity 5 or more days / week, or < 60 min of vigorous activity weekly

* High Blood Glucose: fasting blood glucose ≥ 100mg/dL; non-fasting blood glucose ≥ 140mg/dL

² Excess costs include medical expenditures such as inpatient care, outpatient care, emergency department visits, retail prescriptions, and preventive care.

Based on several sources included in the references, the excess annual costs associated with certain modifiable risk factors are as follows:

* Obesity: \$1,000 [Goetzel, 2020]

* High Blood Pressure: \$1,077 [Kowlessar, 2011]

* High Blood Glucose: \$1,694 [Goetzel, 2020]

* Smoking: \$659 [Adams, 2020]

* Sedentary Lifestyle: \$421 [Goetzel, 2020]

Lastly, improvements in modifiable risk factors have been shown to have an even greater impact on improving productivity and decreasing presenteeism. Specifically, Riedel et al. have determined that each risk per employee results in \$1,494 in productivity loss (based on an average salary of \$50,000). Under Truist's average salary, each risk translates to \$2,343 of annual productivity loss. Next, looking at the eliminated risk factors from Table 1 as well as additional factors like cholesterol, high LDL, seat belt use, and alcohol consumption, the program has eliminated 10,878 risks to date. From a productivity standpoint, this translates to more than \$25.4 million in increased productivity annually.

Aggregating just the benefits of increased productivity (\$25.4 million) and the estimate of decrease in excess medical expenses (\$6.2 million), the total annual financial benefit for Truist's Peak Health program exceeds \$31.8 million.

While this case study includes conservative financial impact estimates, it is worthwhile to reflect on the comments of Steve Reeder, EVP at Truist, and Director of Well-being who has witnessed firsthand the impact of the program on Truist (formerly BB&T) employees and the health plan for over three decades, Reeder's comment (see the testimonial on the prior page) that the program has reduced medical claims by over 10% annually further accentuates the program's financial impact.

Lower Risk and Optimized Medical System Utilization

For self-insured employers like Truist, it is critical to see that the Peak Health wellness program not only yields tangible results on employee health, but that this correlates with lower health risks and optimal medical system utilization. Progression in these metrics typically results in lower claims, which can ultimately yield lower insurance premiums for the employer and/or employee.

Table 2 compares participants and non-participants across both demographic risk and forward-looking risk.

While the non-participants (who are younger, on average, than the participants) have an understandably lower demographic risk than participants, their forward-looking risk is counter-intuitively higher than participants. We could therefore infer that because program participants are engaging in healthier behaviors and experiencing healthier outcomes, their overall forward-looking risk is actually lower, despite their higher demographic risk.

Table 2: Comparison of Demographic and Relative Risk for Program Participants and Non-Participants

	Demographic Risk	Avg Risk Score
Non-Participants	1.20	1.69
Participants	1.28	1.50

Further, Table 3 compares participants and non-participants across medical system utilization as well as predicted costs. On a normalized basis (i.e., per 1,000 employees), participants have had fewer hospital admissions and ER visits than non-participants, and more office visits. This is preferred behavior in terms of medical system utilization. We want employees to visit their doctors to complete gaps in care and not deteriorate to the point that they need to go to the ER and/or be admitted. Additionally, this utilization of the health system for preventative care (vs. reactive care in an ER or hospital) translates to lower costs. The last column of Table 3 supports this assertion, showing that despite their higher demographic risk, program participants are predicted to have lower medical costs than their non-participant counterparts.

Table 3: Comparison of Medical System Utilization and Predicted Costs for Program Participants vs. Non-Participants

	Admits / 1,000	ER visits / 1,000	Office Visits / 1,000	Predicted Cost
Non-Participants	63	237	3,917	\$8,673
Participants	38	147	4,224	\$8,562

Conclusion

In summary, whether considering critical factors important to the employer, the employees, or both, the Peak Health program has proven highly beneficial to Truist. The sustained results also support maintaining the wellness program in order to continue realizing these benefits.

References

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